IMPORTANT

Remember to include your e-mail address when completing your application.

Providing your e-mail address allows us to notify you via e-mail when we receive your application and when we issue your license. These e-mails will contain useful information on how to check the status of your application and how to verify licensure.

Some of our forms have not yet been modified to include e-mail addresses. If the attached form does not include an area in which to enter your e-mail address, or if you need more room, please write your e-mail address on the line below and attach this page to the front of your application. Thank you.

E-Mail:

_____

GEORGIA BOARD OF NURSING
Professional Licensing Boards Division
P.O. Box 13446
Macon, Georgia 31208
Telephone: (478) 207-2440
Fax: (478) 207-1660
Web Site: www.sos.georgia.gov/plb/rn

REINSTATEMENT OF LICENSURE AS A REGISTERED PROFESSIONAL NURSE AND/OR AUTHORIZATION AS A CERTIFIED NURSE-MIDWIFE, NURSE PRACTITIONER, CERTIFIED REGISTERED NURSE ANESTHETIST OR CLINICAL NURSE SPECIALIST AND PSYCHIATRIC/MENTAL HEALTH.

FAILURE TO READ AND FOLLOW INSTRUCTIONS WILL DELAY PROCESSING THE APPLICATION. THE APPLICATION WILL BE RETURNED IF THE FORM IS ALTERED IN ANY WAY.

A. If applying for reinstatement of the RN licensure, complete PART I only. Answer all questions. A non-applicable response should be indicated as such.
B. Enclose your NON-REFUNDABLE application fee in the amount of $90.00 payable to Georgia Board of Nursing. Mail to the Board office at the address on the application.
C. An applicant must be able to document three (3) months or 500 hours of licensed practice as a registered nurse or graduation from a nursing education program within the four (4) years immediately preceding the date of current application. In the absence of this requirement, the applicant must document completion of a Georgia Board-approved reentry or refresher program within the four (4) years immediately preceding the date of current application. Refer to www.sos.georgia.gov/plb/rn for reentry information or contact the Board office at (478) 207-2440.
D. Any person who is licensed as a registered professional nurse shall identify that he or she is so licensed by displaying either the title "registered professional nurse" or "registered nurse" or the abbreviation "R.N." on a name tag or other similar form of identification during times when such person is providing direct patient care.
E. Upon receipt of the permanent license, the applicant should verify the accuracy of all information. Notify the Board in writing immediately if there is an typographical error.
F. An applicant must notify the Board in writing of an address change within thirty (30) days.
G. An application is valid for one year from the date of submission. After one year, an applicant must submit a new application, photograph, required fee, and supporting documents.
H. An applicant who is under investigation for possible violation of any Nurse Practice Act may not be issued a license until the matter is resolved to the satisfaction of the Board. If charges are substantiated, the license may be denied or sanctioned despite the applicant meeting all other criteria for licensure.
I. A verification of employment form should be provided from each employment within the last 4 years listed/completed by the applicant in section 15 on this application.

An applicant for licensure who has begun employment as a registered nurse in Georgia prior to issuance of a license shall be subject to referral to the Attorney General's office for a Consent Order, which may include a public reprimand and a fine. The Board requires a personal, notarized letter of explanation from the applicant and detailed employment information from the employer HR department for any RN/APRN practice in Georgia without valid license/authorization.

Reinstatement of Authorization as a Certified Nurse-Midwife, Nurse Practitioner, Certified Registered Nurse Anesthetist and/or Clinical Nurse Specialist, Psychiatric/Mental Health.

A. For reinstatement of APRN authorization, you must complete PART I and PART II of the application even if you are currently licensed as an RN in Georgia.
B. If you are currently licensed as an RN in Georgia and applying to reinstate authorization as an APRN, enclose a nonrefundable application fee in the amount of $90.00 payable to the Georgia Board of Nursing. If applying to reinstate both RN licensure and APRN authorization, enclose the fee in the amount of $180.00.

C. VERIFICATION OF NATIONAL CERTIFICATION: Request your certification board to verify your certification status on the enclosed Verification of National Certification form. The completed certification form must have the agency seal and may be forwarded to the Board by you as long as it is in a sealed envelope from the certification organization. Applicants must contact National Certifying Corporation, Pediatric Nursing Certification Board and CRNA credentialing organizations recognized by the Georgia Board of Nursing and request verifications be sent electronically to PLB-Healthcare3@sos.state.ga.us CNS, PMH: Please refer to item D. CNMs: Please refer to item E.

D. Clinical Nurse Specialist/Psychiatric Mental Health ONLY: Prior to January 1, 1999, initial authorization was based on a master's or higher degree in nursing with specialization in psychiatric/mental health nursing or certification. Verification of certification must be provided for any authorization based on certification issued by the board.

E. CNMs ONLY: If certified as a nurse-midwife prior to January 1, 1996, submit evidence of enrollment in the Continuing Competency Assessment Program of the American College of Nurse-Midwives which bear current cycle dates. If certified on or after January 1, 1996, you must comply with item C: Verification of National Certification.

F. A separate application is required for practice in each category of advanced nursing (ex. CNM and NP, NP and CNS, PMH, etc.).

G. The name in which you are applying to reinstate RN licensure or APRN authorization must be the same. If your name has changed since initial licensure/authorization in Georgia, you must submit with your reinstatement application a copy of the legal document to support the name change, i.e., a marriage certificate, divorce decree, etc.

H. Mail original application, fee, and any supporting documents to the Board address. No photocopies or facsimiles of the application will be accepted

Enclosures –
Verification of National Certification (for APRNs)
Verification of Employment
Criminal Background Consent Form
Documentation to Determine Qualified Alien Status

FOR BOARD USE ONLY
Amount Submitted _____
Date _____
Receipt # _____

FOR BOARD USE ONLY
Certificate Number _____
Date Issued _____
Applicant No. _____

GEORGIA BOARD OF NURSING

Post Office Box 13446 • Macon, Georgia 31208 • (478) 207-2440
www.sos.georgia.gov/plb/rn

APPLICATION FOR Licensure Reinstatement for Registered Professional Nurse and/or Reinstatement of Authorization as an Advanced Practice Registered Nurse

License Type: ____ Reinstatement RN ____ Reinstatement APRN
( ) Reinstatement RN: Application Fee $90 (non-refundable)
License# RN_____
( ) Reinstatement APRN: Application Fee $90 (non-refundable) A separate application is necessary for each APRN title request.
____ CNS/PMH ____ CNM
____ NP ____ CRNA

Part I: Personal Information:

1. Legal Name to appear on License: _____
LAST FIRST MIDDLE MAIDEN

2. Name as shown on exam records, transcripts or any documentation provided to the Board including maiden name (if different):
_____
LAST FIRST MIDDLE MAIDEN

3. Social Security #*: ___ - ___ - ____ Date of Birth: MM - DD - YYYY

*This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. §19-11-1 and O.C.G.A. §20-3-295, 42 U.S.C.A. §551 and 20 U.S.C.A. §1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes.

4. Gender: ☐ Male ☐ Female Race:_____ Ethnicity: _____ (Hispanic or Latino) _____(Not Hispanic or Latino)

5. Residential (Physical) Address: _____
NUMBER AND STREET(P.O. BOX NOT ACCEPTABLE) APT #

_____ ____ _____ - ____
CITY STATE ZIP

6. Mailing Address: _____
(*ADDRESS WILL APPEAR ON WEBSITE) NUMBER AND STREET (P.O. BOX ACCEPTABLE) APT #

_____ ____ _____ - ____
CITY STATE ZIP

7. Daytime Phone #: ___ - ___ - ____ Evening Phone #: ___ - ___ - ____

8. E-mail Address: _____ Fax Number:_____

9. ☐ I am a U.S. citizen ☐ I am not a U.S. citizen but am a qualified alien under the federal Immigration and Naturalization Act, and I am lawfully present in the United States. If you are not a U.S. citizen, you must complete the attached form, DOCUMENTATION TO DETERMINE QUALIFIED ALIEN STATUS, and provide required documentation.

10. Country of Birth:_____

You must immediately notify the Board in writing of address changes. *Pursuant to O.C.G.A. 43-1-2 (k) your name, mailing address and license number are public information.

EDUCATIONAL INFORMATION

11. Basic Nursing Education: _____

School City, State Month/Year of Graduation

12. Education Completed: (Check all that apply.)

- ❑ Associate Degree
- ❑ Diploma
- ❑ BSN
- ❑ APRN Certificate
- ❑ Master's Degree in Nursing
- ❑ Post Master's Certificate
- ❑ Doctoral Degree
- ❑ Post Doctoral Certificate
- ❑ Other (please specify)_____

13. Date of original RN licensure in Georgia: _____ Georgia license number:

Date license expired (or will expire): _____ RN _____

14. State of Original RN Licensure in the United States or its territories:

_____ Year issued: _____

15. Have you practiced as a licensed registered nurse or APRN for compensation for at least three (3) months or 500 hours during the four (4) years immediately preceding the date of this application?

(Any applicant that does not meet these practice requirements MUST complete a Georgia Board of Nursing Approved Re-entry Program.) ❒ No Yes ❒

The Board of Nursing makes licensure decisions based on the information submitted on this application. Please refer to the Nurse Practice Act, OCGA 43-26-3(6) for the "Practice of Nursing" Definition. If the practice does not fall within the definition of the Practice of Nursing and does not require RN licensure, DO NOT list it below. Any applicant practicing as an RN without licensure and/or APRN Authorization may be subject to disciplinary action at the Board's discretion. The Board requires a personal, notarized letter of explanation from the applicant and detailed employment information from the employer HR department for any RN/APRN practice in Georgia without valid license/authorization. A verification of employment form must be provided for each employment within the last 4 years listed on the grid below.

Employer's Name/Address City/State	Actual Workplace Location Facility Name/City/State	Position Title	Is RN Licensure Required?	Is APRN Authorization required?	Dates From - To (mo/yr)-(mo/yr)
A.					
B.					
C.					

PREVIOUS DISCIPLINARY AND CRIMINAL CONVICTION INFORMATION

16. Board Disciplinary Actions/Legal Convictions: Answer BOTH Questions:

A. Have you ever been arrested, convicted, sentenced, plead guilty, plead nolo contendere or given first offender status which is: (a) a misdemeanor; (b) a felony; (c) a crime involving moral turpitude; (d) a crime violating a federal law involving controlled substances, dangerous drugs or a DUI /DWI; (e) any offense other than a minor traffic violation? Note: Even if probation completed or first offender status granted.

❒ No Yes ❒

If "yes", have you included a certified copy of the court records and final disposition in a sealed envelope from the court with your application? ❒ No Yes ❒

Have you included a personal, detailed notarized letter explaining each incident? ❒ No Yes ❒

B. Has <u>any</u> licensing board or agency in Georgia or any other state ever:

(a) denied your application, for licensure, renewal or reinstatement?	❒ No	Yes ❒
(b) revoked, suspended, restricted or probated your license?	❒ No	Yes ❒
(c) requested or accepted surrender of your license?	❒ No	Yes ❒
(d) reprimanded, fined or disciplined you?	❒ No	Yes ❒

If "yes", have you included a certified copy of that board or agency's action against your license with Relevant supporting documents in a sealed envelope from the board or agency with your application?

❒ No Yes ❒

Have you included a personal, detailed notarized letter explaining each incident? ❒No Yes ❒

Provide the name of the agency or board in the space provided.

_____

Name of agency or board

PASSPORT PHOTO

17. Photograph:

Provide one passport photograph taken within the last six (6) months. Sign back of photograph.

(Tape Top Only)

Attach
Photo Here

NOTARIZED SIGNATURE BY APPLICANT

13. The facts set forth in this application for licensure as a Registered Professional Nurse or authorization as an Advanced Practice Registered Nurse in Georgia are true and complete to the best of my knowledge. I understand false statements on this application may be considered sufficient cause for denial of licensure and/or authorization. The Georgia Board of Nursing is hereby authorized to request any information necessary to process my application.

_____ _____

Date Application Submitted Signature of Applicant

Sworn to and subscribed before me this _____ day of _____, 200____.

_____

(Signature of Notary Public)

My Commission Expires: _____

Note: If you are applying to reinstate authorization to practice as a CNM, NP, CRNA or CNS, PMH proceed to part II; otherwise,

Have you...

- ❑ Enclosed a $90.00 non-refundable application fee ($180 if reinstating both RN and APRN authorization) for RN licensure?
- ❑ Answered each question?
- ❑ Recorded address for each employer?
- ❑ Included passport photograph?
- ❑ Included all sealed documents and notarized letter of explanation?

Mail to:

Georgia Board of Registered Professional Nursing
P.O. Box 13446237
Macon, Georgia
31208

PART II

PLEASE COMPLETE THIS SECTION FOR REINSTATEMENT OF ADVANCED NURSING PRACTICE AUTHORIZATION (CNM, NP, CRNA OR CNS AND PMH) IN ADDITION TO PART I.

A nonrefundable application fee of $90.00 is required for advanced nursing practice authorization.

Indicate for which of the following you are applying (check only one per application):

- ❑ Certified registered nurse anesthetist
- ❑ Certified nurse-midwife
- ❑ Nurse Practitioner _____

  Specify Type
- ❑ Clinical nurse specialist, psychiatric/mental health

1. Advanced Practice Nursing Education (check one):
   - ❑ Certificate Program
   - ❑ Degree Program

_____

Name of School/Program

_____

Street or P. O. Box City, State Zip Code

Dates Attended: From: _____ To: _____

2. Name of national certification board: _____

   Address: _____

   Street or P.O. Box City, State Zip Code

3. National Certification Number (if applicable): _____

Complete the required portion and send the attached Verification of Certification to your certifying board and request it send the Verification of Certification in a SEALED ENVELOPE to you to be forwarded with your application.

Have you…

- ❑ Enclosed a $90.00 application fee for APRN authorization?
- ❑ Answered each question?
- ❑ Included Verification of National Certification with your application?

Mail to:
Georgia Board o Nursing
P.O. Box 13446237
Macon, Georgia
31208

GEORGIA BOARD OF NURSING

237 Coliseum Drive
Macon, Georgia 31217-3858
(912) 207-2440

VERIFICATION OF NATIONAL CERTIFICATION AS A NURSE-MIDWIFE, NURSE PRACTITIONER, NURSE ANESTHETIST OR CLINICAL NURSE SPECIALIST, PSYCHIATRIC/MENTAL HEALTH

APPLICANT: Complete this section and forward to your national certification board. Inquire if there is a fee for completing this form and mail fee with this form to your respective national certification board. CERTIFIED NURSE-MIDWIVES who were certified prior to January 1, 1996 must submit a copy of their enrollment card from the American Council of Nurse-Midwives' Continuing Competency Assessment Program which bears current cycle dates. * National Certifying Corporation, Pediatric Nursing Certification Board and CRNA credentialing organizations must be contacted by the applicant to request verifications be submitted electronically to the Georgia Board of Nursing; PLB-Healthcare3@sos.state.ga.us.

Name _____
Last First Middle Maiden

Address _____
Street City State Zip

Social Security # _____

Date of Birth _____

Name of Advanced Practice Nursing Education Program _____

Location (city/state) _____

Date of Completion/Graduation _____

National Certification Board _____

Type of Certification _____

Certification Number (if applicable) _____

I hereby authorize the designated national certification board to furnish the information requested to the Georgia Board of Nursing.

_____
Signature Date

FOR CERTIFICATION BOARD ONLY

This is to certify that the above named was issued certification _____ number to practice as a _____ on _____.
(state type of certification) (Initial certification date)

Initially Certified by: _____ Examination _____ other Evaluation (Please Explain)

Certificate/Recertification Expires: _____

_____
Signature Date

_____
Title

BOARD SEAL

_____
Board

_____
Address

_____
Telephone #

GEORGIA BOARD OF REGISTERED PROFESSIONAL NURSING
237 Coliseum Drive
Macon, Georgia 31217

VERIFICATION OF EMPLOYMENT

Instructions:

1. Applicant: Complete Section I and sign.
2. Submit this form to all nursing related employers in the 4 years preceding this application (Personnel Director, Human Resources Department) that can provide verification of your practice as a registered nurse. Ask the employer to complete the form and place it in a sealed envelope by them for you to be submit with your application.

Section I (To be completed by applicant)*The name and address of your employer on this form must match the name and address you listed under "Nursing Related Employment" on the application.

Section I:

Printed Name of Applicant: _____
Last First Middle Maiden

Applicants Address: _____
Street City State Zip Code

RELEASE: I do hereby consent to and authorize the release of any and all records and information concerning my employment to the Georgia Board of Registered Nursing. I understand this information is required as part of the application for licensure process.

Signature of Applicant _____ Applicant Phone Number (s)_____

APPLICANT – DO NOT WRITE BELOW THIS LINE:

Section II (To be completed by person verifying employment):
Instructions: 1. Complete Section II of this form. 2. Registered Nursing employment must have been for compensation. 3. Each Title held with one employer requires a separate verification form completed. 4. Return the form to the applicant.

1. Name of Facility/Business/Employer: _____ Phone Number: ( )_____
   Is this a federal agency of the United States Government? ❒ No Yes ❒

2. Physical Address of Location: _____
   City State Zip

3. Employee's Position/Title: _____

4. Is an RN license necessary for employment in this position? ❒ No Yes ❒

5. Is an APRN authorization necessary for employment in this position? ❒ No Yes ❒

6. Identify the Actual Physical Location where the employee practiced to include facility name, city/state if different than # 2 above or indicate same as above:
_____

7. Employment Dates: From: _____ (mo/yr) - To: _____(mo/yr)
   Were there any periods of extended absence during employment? ❒ No Yes ❒ Please provide dates _____

LIST BELOW THE NUMBER OF HOURS WORKED PER YEAR AND Job Description: List below the number of hours worked per year and duties:

Year	Hours worked	Job Description

8. Printed name and title of person verifying employment: _____

9. Signature/Date of Employer Representative completing this form:_____ Date_____
(Employer Signature/notarization valid only if occurring on same date.)
Sworn to and subscribed before me this _____ day of _____, 20____
Notary Public Signature _____ (Notary Seal)
My commission expires: _____

DOCUMENTATION TO DETERMINE QUALIFIED ALIEN STATUS

Please indicate below which documentation you will submit to show proof you are a qualified alien under the Federal Immigration and Naturalization Act.

Alien Lawfully Admitted for Permanent Residence:
_____ - INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card"
_____ - Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94

Asylee:
_____ - INS Form I-94 annotated with stamp showing admission under §208 of the INA
_____ - INS Form I-688B (Employment Authorization Card) annotated "27a.12 (a) (5)"
_____ - INS Form I-766 (Employment Authorization Document) annotated "A5"
_____ - Grant letter from the asylum office of INS
_____ - Order of an immigration judge granting asylum

Refugee:
_____ - INS Form I-94 annotated with stamp showing admission under §207 of the INA
_____ - INS Form I-688B (Employment Authorization Card) annotated "274a.12 (a) (3)
_____ - INS Form I-766 (Employment Authorization Document) annotated "A3"
_____ - INS Form I-571 (Refugee Travel Document)

Alien Paroled Into the U.S. for at Least One Year:
_____ - INS Form I-94 with stamp showing admission for at least one year under §212(d) (5) of the INA

Alien Whose Deportation or Removal Was Withheld:
_____ - INS Form I-688B (Employment Authorization Card) annotated "274a.12 (a) (10)
_____ - INS Form I-766 (Employment Authorization Document) annotated "A10"
_____ - Order from an immigration judge showing deportation withheld under §241 (b) (3) of the INA

Alien Granted Conditional Entry:
____ - INS Form I-94 with stamp showing admission under §203 (a) (7) of the INA
_____ - INS Form I-688B (Employment Authorization Card) annotated "274a.12 (1) (3)
_____ - INS Form I-766 (Employment Authorization Document) annotated "A3"

Cuban/Haitian Entrant:
_____ - INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card") with the code CU6, CU7, or CH6
_____ - Unexpired temporary I-551 stamp in foreign passport or on INS Form I-94 with the code CU6 or CU7
_____ - INS Form I-94 with stamp showing parole as "Cuba/Haitian Entrant" under §212(d) (5) of the INA

Alien Who Has Been Battered or Subjected to Extreme Cruelty:
_____ - INS petition and appropriate supporting documentation

_____ _____
(Applicant's Signature) (Date)

OFFICE OF SECRETARY OF STATE
PROFESSIONAL LICENSING BOARDS DIVISION
GEORGIA STATE BOARD OF NURSING
237 Coliseum Drive
Macon, Georgia 31217
(478) 207-2440

CONSENT FORM

I authorize the Georgia Board of Nursing to conduct a background investigation of me to determine my suitability for licensure. I give my consent for full and complete disclosure of all records and information concerning myself to the Board, their authorized representatives, or any other persons deemed necessary by the Board in determining my suitability, whether such records and information are of a public, private, or confidential nature, to include criminal history records. This authorization will remain in effect for the duration of my active licensure status with this state or until cancelled by me in writing.

_____
Applicant's Full Name (Printed)

_____

_____
Physical Address (P.O. Boxes NOT Accepted)

_____ _____ _____ _____
Sex Race Date of Birth Social Security Number

Place of Birth (City/State): _____

Aliases or Maiden Name: _____

_____ _____
(Signature of Applicant) (Date)